Building Systems of Care: A Primer on Designing and Implementing Effective Systems of Care

The TA Network for Children's Behavioral Health

The National Wraparound Implementation Center

The Institute for Innovation and Implementation

Topeka, Kansas

June 17-18, 2019

TA NETWORK

DEPARTMENT OF HEALTH & HUMAN SERVICES, USA

SAMHSA

Substance Abuse and Mental Health Services Administration

This training is hosted by the National TA Network for Children's Behavioral Health, operated by and coordinated through the University of Maryland.

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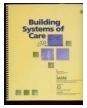

Definition, History, Values, Populations

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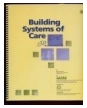
Definition of a System of Care



A system of care incorporates a broad, flexible array of effective services and supports for a defined population that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, has supportive policy and management infrastructure, and is data-driven.

Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

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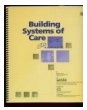

Milestones in Evolution of

2013 SAMHSA Behavioral Health Disparity Impact Statements - ***required of SOC Expansion and other grantees***

2013 FREDLA – ***family-run organizations***

2011 SAMHSA SOC Expansion grants

2010 CMS CHIPRA Quality grants – ***fidelity Wraparound through Care Management Entities***

2010 Health Reform - ***system of care principles in health care***

2003 Children's Bureau - ***child welfare system of care grants***

2003 YouthMove – ***youth movement***

2002 President Bush's New Freedom MH Commission - ***children's recommendations***

1997 Robert Wood Johnson Foundation Mental Health Services Program for Youth – ***introduction of managed care approaches to SOC***

1993 President Clinton's Health Care Reform Task Force - children's plan

1992 Annie E Casey Foundation Urban Mental Health Initiative

1992 SAMHSA CMHI - ***services and supports***

1989 Federation of Families –*family movement*

1984 CASSP – ***interagency coordination***

1982 Unclaimed Children

Pires, S. (2018) Washington, D.C.: Human Service Collaborative for University of Maryland Baltimore, Pre-Institute *Building Systems of Care*

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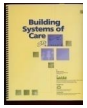
Historic/Current Systems Problems



Lack of home and community-based services and supports	Deficit-based/medical models, limited types of interventions	Patterns of utilization; racial/ethnic disproportionality and disparities	Poor outcomes
Cost	Rigid financing structures	Administrative inefficiencies; fragmentation	Knowledge, skills and attitudes of key stakeholders

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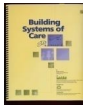
Characteristics of Systems of Care as Systems Reform Initiatives



From:

- Fragmented service delivery
- Categorical programs/funding
- Limited services
- Reactive, crisis-oriented
- Focus on "deep end," restrictive
- Children/youth out-of-home
- Centralized authority
- Foster "dependency"

To:

- Coordinated service delivery
- Blended resources
- Comprehensive service array
- Focus on prevention/early intervention
- Least restrictive settings
- Children/youth within families
- Community-based ownership
- Build on strengths and resiliency

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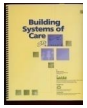
Frontline Practice Shifts



From:

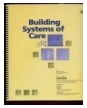
- Control by professionals (*I am in charge)*
- Only professional services
- Multiple case managers
- Multiple service plans (meeting needs of agencies)
- Family/youth blaming
- Deficits focused
- *Mono Cultural*

To:

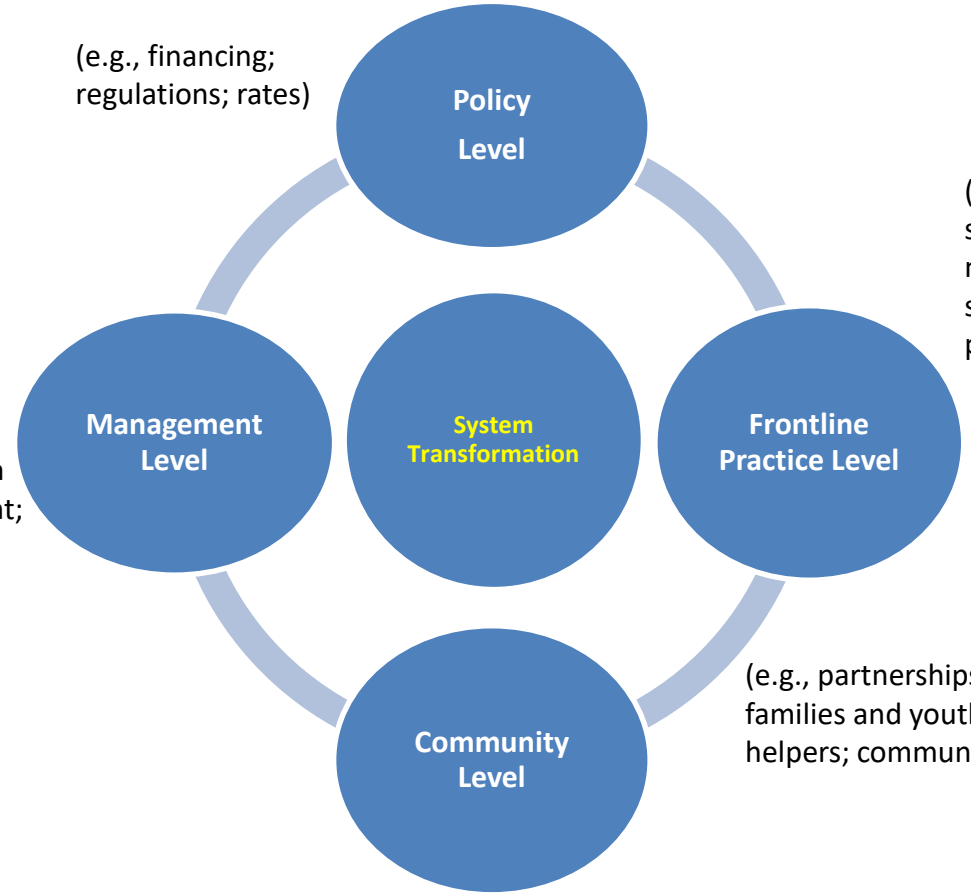
- Partnerships with families/youth (*acknowledging a power imbalance*)
- Partnership between natural and professional supports/services
- One care coordinator
- Single, individualized child and family plan (meeting needs of family and youth)
- Family/youth partnerships
- Strengths focused
- Cultural/linguistic competence

Orrego, M. E. & Lazear, K. J. (1998) EQUIPO: Working as Partners to Strengthen Our Community and Conlan, L. Federation of Families for Children's Mental Health

System Change/Transformation Focus



(e.g., financing; regulations; rates)



(e.g., assessment; service planning; care management; services/supports provision)

(e.g., data; quality improvement; human resource development; system organization)

(e.g., partnerships with families and youth; natural helpers; community buy-in)

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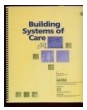

System of care is, first and foremost,

a set of values and principles that provides an organizing framework for systems reform on behalf of children, youth and families.

- Family-driven and youth-guided
- Home and community based
- Strengths-based and individualized
- Coordinated across providers and systems
- Trauma-informed
- Commitment to health equity through cultural and linguistic competency
- Connected to natural helping networks
- Resiliency-and recovery-oriented
- Data-driven, quality and outcomes oriented

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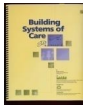
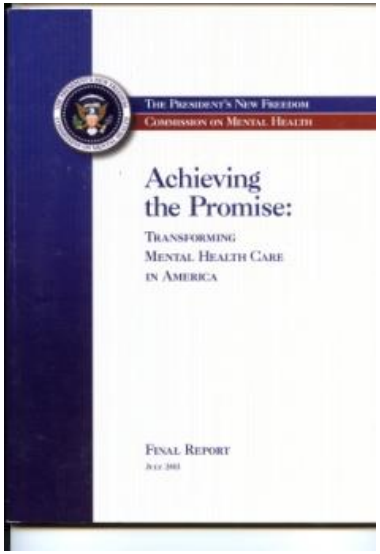
Definition of Family-Driven

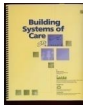


Family-driven means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- choosing culturally and linguistically competent supports, services, and providers
- setting goals
- designing, implementing, and evaluating programs
- monitoring outcomes
- partnering in funding decisions



Definition of Youth Guided



"*Youth Guided* means to value youth as experts, respect their voice, and to treat them as equal partners in creating system change at the individual, state, and national level."

YOUTH M.O.V.E. NATIONAL

www.youthmovenational.org

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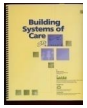
Family Members and Youth: Shifts in Roles and Expectations



*Recipients of information

*Unheard voice in program evaluation

*Recipients of services

*Uninvited key stake holders in training initiatives

*Anger adversity & resistance

*Passive partners in service planning

*Participate in program evaluation

*Partners in planning and developing services

*Participants in training initiatives

*Self- advocacy

*Service planning team leader

*Partner (or independent) in developing and conducting program evaluation

*Service providers

*Partners and independent consultants

*Advocacy & peer support

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Lazear, K. & Conlan, L. (2004). *"Primer Hands On" for Family Organizations*. Human Service Collaborative: Washington, D.C.

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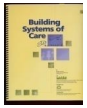

Family & Youth Roles in Systems of Care

Roles	Descriptions
Peer Support Services	• Information and referral • Parent/Peer education • Family & youth mentors • Supervisor/management
Service Delivery	• Peer navigators • Care coordinators • Family & youth support partners • Project directors
Outreach & Public Awareness	• Presentations • Testimony • Community Resource Fairs
Quality Assurance	• Evaluation interviewers • Board representation
Training & Technical Assistance	• Curriculum development • Workshops • Co-trainers • Consultants • Certification

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Conlan, L. (2013) Primer Hands On , Human Service Collaborative: Washington, D.C.

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National Culturally and Linguistically Appropriate Services (CLAS) Standards

www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandards

Lazear, K. (2016) University of South Florida, Tampa, FL and Webster-Bass, S. Voices Institute, Jacksonville, FL

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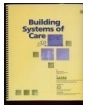
Example of Cross-Agency Responsibility for Behavioral Health Care Delivery for Children/Youth



Dept. of Mental Health

- CMHCs
- State Hospitals
- Residential Treatment Centers

Dept. of Alcohol and Other Drug Abuse Services

- Contracted adolescent SUD OP
- SUD Prevention

Dept. of Public Health

- Maternal and Child Health
- Part C – Early Intervention

Dept. of Health and Human Services - Medicaid

- 3 PCCMs
- 4 MCOs

- Office-based OP
- Psychiatric inpatient in community hospitals
- PRTFs - soon

Voc Rehab, Housing, Employment

Dept. of Social Services – Child Welfare

- Intensive Foster Care & Clinical Services
- Treatment Foster Care
- Intensive Case Management

- Contracted Residential Treatment
- Therapeutic Group Homes

Dept. of Juvenile Justice

- Assessment Center
- Contracted MST, DBT

Dept. of Education

- IDEA
- School-based health centers
- School psychologists and social workers

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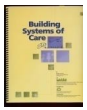
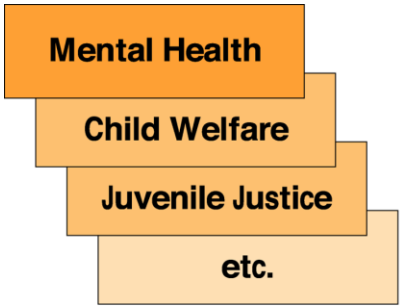
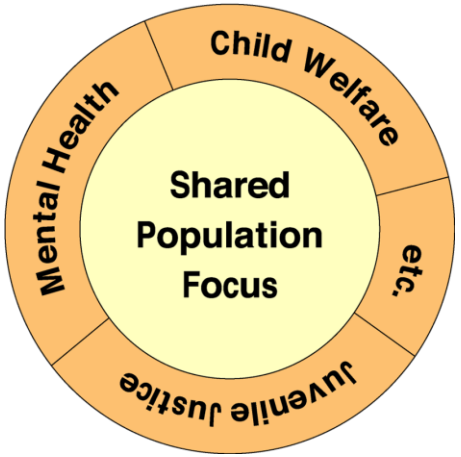


Categorical vs. Non-Categorical System Reforms

Categorical System Reforms



Non-Categorical Reforms



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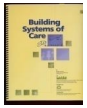
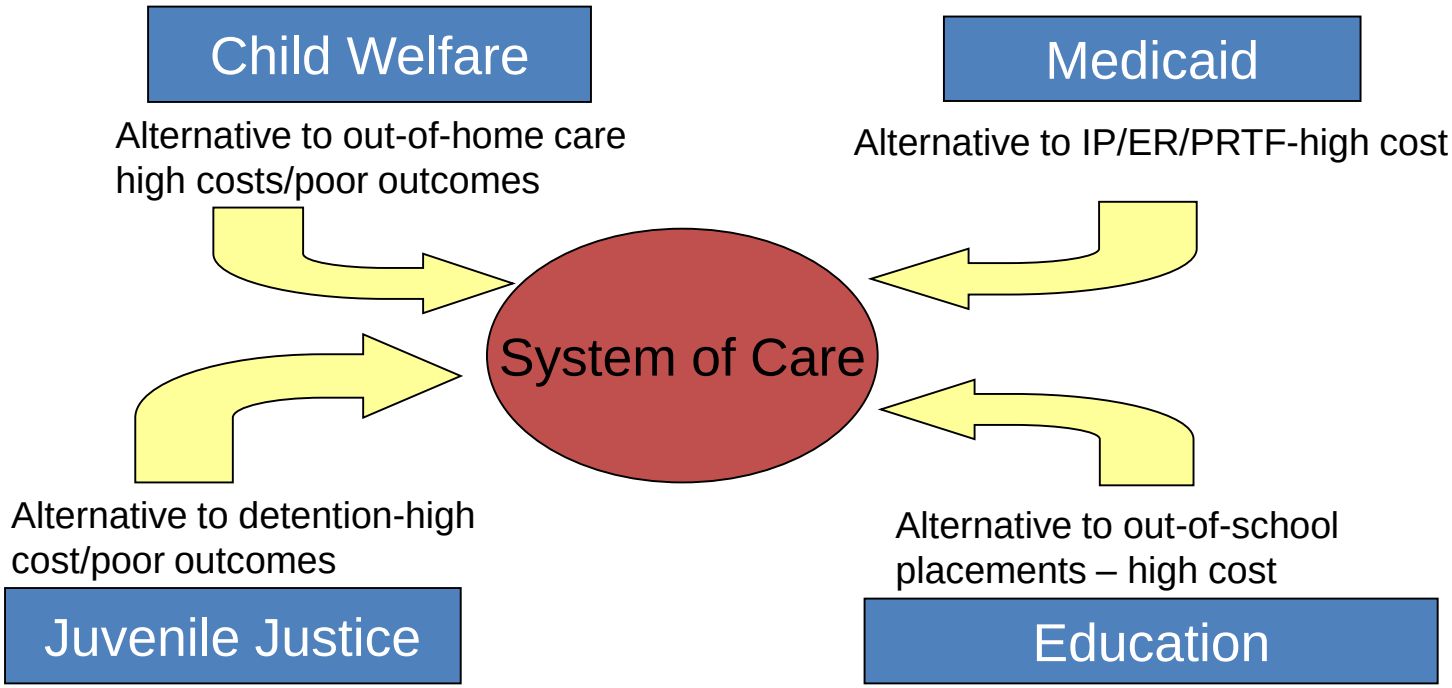
Creating "Win-Win" Scenarios





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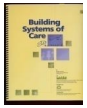
Exercise/Discussion on Values



Planning and Governance

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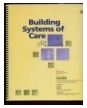
Prevalence of Child Mental Health Disorders



- An estimated 13-20% of children in the United States (up to 1 out of 5 children) experience a mental disorder in a given year…"[1]

- About one out of every ten youth is estimated to meet the Substance Abuse and Mental Health Services Administration (SAMHSA) criteria for a Serious Emotional Disturbance (SED), defined as a mental health problem that has a significant impact on a child's ability to function socially, academically, and emotionally.[2]

[1] Centers for Disease Control and Prevention. Mental health surveillance among children – United States 2005-2011. MMWR 2013;62 (Suppl; May 16, 2013):1-35. The report is available at www.cdc.gov/mmwr

[2] Costello, EJ, Egger, H, Angold, A. 10-year research update review: The epidemiology of child and adolescent psychiatric disorders: 1. Methods and public health burden. J Am Acad Child Adolescent Psychiatry. 2005. Oct; 44 (10): 972-86

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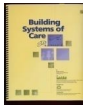

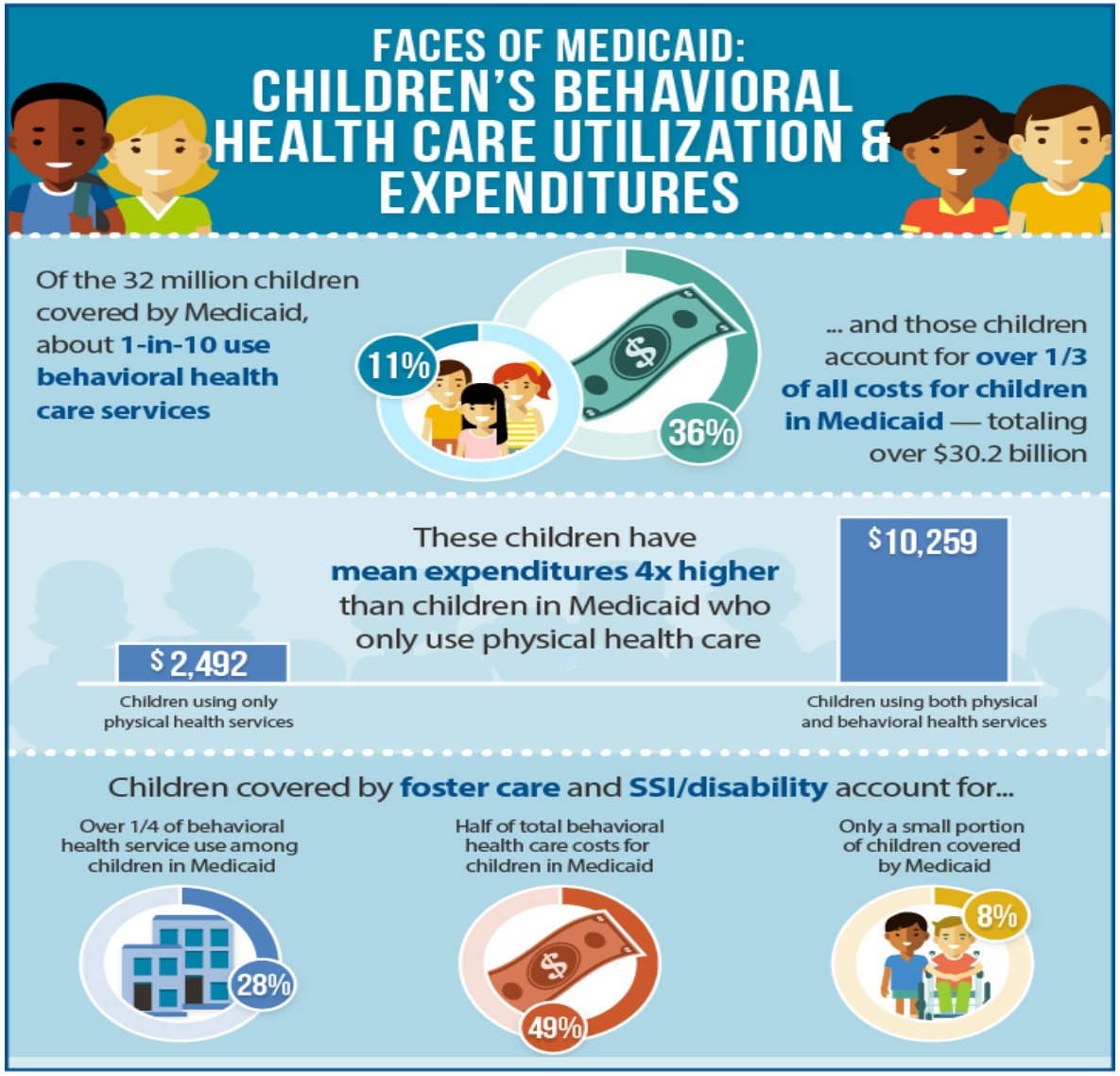

CHCS Center for Health Care Strategies, Inc.
www.chcs.org

Made possible with support from the Annie E. Casey Foundation.

SOURCE: S. Pires, T. Gilmer, K. Allen, and J. McLean. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures, 2005-2011." Forthcoming Fall 2017. Center for Health Care Strategies.

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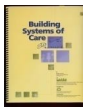

Children Using Behavioral Health Care in Medicaid with Top 10% Highest Expenditures…

- Have mean expenditures of $46,959
  - BH expense: $36,646
  - PH expense: $10,314

Expense is driven by use of behavioral health, not physical health care

Pires, SA, Gilmer, T, Allen, K., McClean, J. 2017. *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures Over Time, 2005-2011*. (In process). Center for Health Care Strategies: Hamilton, NJ

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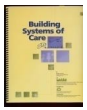

Children and Youth with Serious Behavioral Health Conditions Are A Distinct Population from Adults with Serious and Persistent Mental Illness

Do not have the same high rates of co-morbid physical health conditions.

Are multi-system involved – two-thirds typically are involved with CW and/or JJ systems and 60% may be in special education – systems governed by legal mandates.

Have different mental health diagnoses (ADHD, Conduct Disorders, Anxiety; not so much Schizophrenia, Psychosis, Bipolar as in adults), and diagnoses change often.

Coordination with other children's systems (CW, JJ, schools) and among behavioral health providers, as well as family issues, consumes most of care coordinator's time, not coordination with primary care.

To improve cost and quality of care, focus must be on child and family/caregiver(s) – takes time – implies lower care coordination ratios and higher rates.

Pires, S. March 2013 *Customizing Health Homes for Children with Serious Behavioral Health Challenges.* Human Service Collaborative. Washington, D.C.

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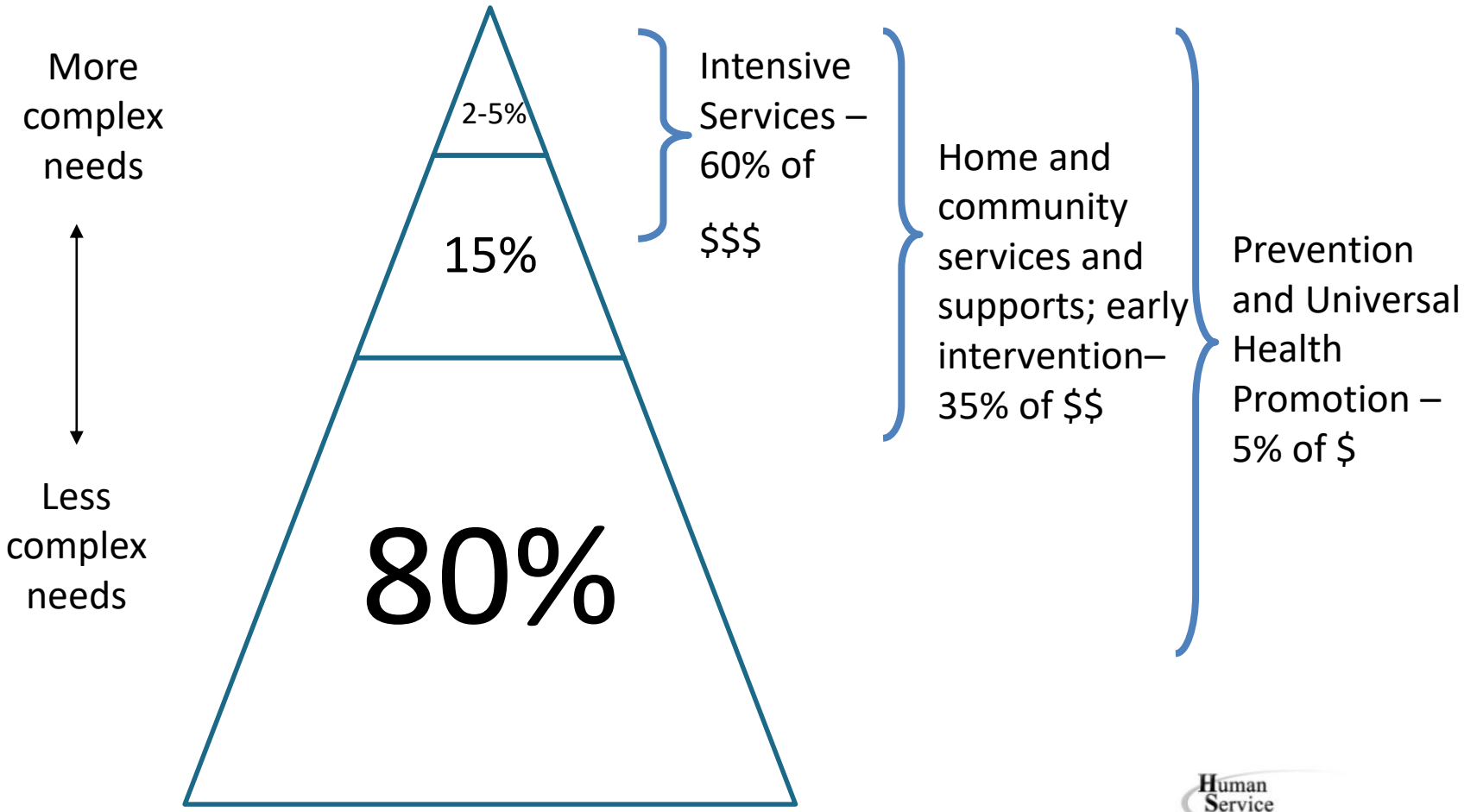
Prevalence/Utilization Triangle



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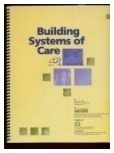
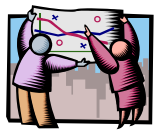
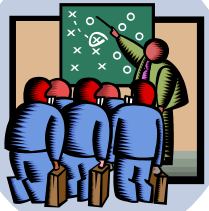
Functions





Planning

Governance



System Management

Pires, S. (2002). *Building Systems of Care: A Primer.* Washington, D.C.: Human Service Collaborative.

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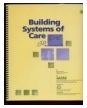
Effective System-Building Process



Leadership & Constituency Building

A Strategic Focus

Orientation to Sustainability

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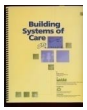

Importance of Federal & State Reforms

- **Health Reform**
  - Medicaid expansion?
  - Managed Care (KanCare)
  - Focus on "whole person," person-centered care
  - Funding for community mental health centers and regional care centers
- **Child Welfare Reforms**
  - Family First Prevention Services
  - Child welfare oversight
- **Juvenile Justice Reforms**
  - Diversion and alternatives to detention
  - Restorative justice
  - Focus on reduction in out of home placement
- **Education Reforms**
  - Positive Behavioral Supports and Interventions
  - Safe and Healthy Schools
  - Early childhood improvements

Human Service Collaborative

Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

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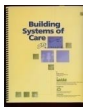


Factors That Impact Design

Financing

Title XIX Funding
-Rehab Option
-Targeted Case Management
Child Welfare
Juvenile Justice
1915 like (i) or (c)
1115 Waiver
CHIP/SCHIP
State Funds

Environment

Political
Perspectives of Leaders
Lawsuits/Settlements
Crisis/Tragedy
Mandates
Community Will
Economy

NJ CSOC

Final System of Care Design

Values & Principles

Priorities

Increase Access to Care
Addressing Urgency
Evidence Informed Care
Care Management
System Coordination
Reduce Institutional Care
Meet the Needs of Particular Populations

Structure

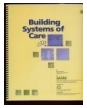
Government
State and County
Existing Reality
Envisioned Ideal
Medicaid Agency
Locus of Control
Leadership Structure

System of Care Functions Requiring Structure

- Planning
- Governance-Policy Level Oversight
- System Management
- Benefit Design/Service Array
- Evidence-Based Practice
- Outreach and Referral
- System Entry/Access
- Screening, Assessment, and Evaluation
- Decision Making and Oversight at the Service Delivery Level
  - Care Planning
  - Care Authorization
  - Care Monitoring and Review
- Care Management or Care Coordination
- Crisis Management at the Service Delivery and Systems Levels
- Utilization Management
- Family Involvement, Support, and Development at all Levels
- Youth Involvement, Support, and Development at all Levels
- Staffing Structure
- Staff Involvement, Support, Development
- Orientation, Training of Key Stakeholders
- External and Internal Communication
- Social Marketing
- Provider Network
- Protecting Privacy
- Ensuring Rights
- Transportation
- Financing
- Purchasing/Contracting
- Provider Payment Rates
- Revenue Generation and Reinvestment
- Billing and Claims Processing
- Information Management & Communications Technology
- Quality Improvement
- Evaluation

Pires, S. (2002). *Building Systems of Care: A Primer*. Washington, D.C.: Human Service Collaborative

Structuring Planning



- Leadership
- Staffing
- Time and place of meetings
- Stakeholder involvement and supports
- Committees, work groups, focus groups
- Communication and dissemination of information
- Outreach to and involvement of families and youth
- Outreach to and involvement of diverse and disenfranchised constituencies, use of cultural brokers
- Linkage to related reform/planning initiatives
- Resources

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Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

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Critical Steps in a Planning Process

- ✓ Identify your population(s) of focus.
- ✓ Agree on underlying values and intended outcomes.
- ✓ Identify services/supports and practice model to achieve outcomes (map existing strengths and needs)
- ✓ Identify how services/supports will be organized (so that all key stakeholders can draw the system design).
- ✓ Identify the administrative/system infrastructure needed to support the delivery system and capacity building reqs (e.g., training)
- ✓ Conduct an expenditure and utilization analysis (e.g., how population has used services and can be expected to) - Cost out the system of care.
- ✓ Develop a strategic financing and sustainability plan.

Pires, S. 2006. Human Service Collaborative. Washington, D.C.

Governance

Decision making at a policy level that has legitimacy, authority, and accountability.

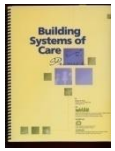
System Management

Day-to-day operational decision making

Pires, S. (1995). *Definition of governance*. Washington, DC: Human Service Collaborative.

For the Governance Body to be effective, its members must have decision making authority regarding resources and policies needed to build and sustain the System of Care.

Key Issues for Governing Bodies



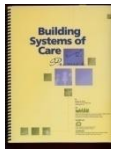
- Has authority to govern
- Is clear about role, scope, operational practices and procedures
- Is representative

- Has the capacity and credibility to govern
- Has training and coaching on conflict resolution, effective working relationships

- Assumes shared accountability across systems for population(s) of focus
- Operates in a transparent manner to assure public confidence

Pires, S. (2000). *Key issues for governing bodies*. Washington, DC: Human Service Collaborative

System Management: Day-to-Day Operational Decision Making



Key Issues

- Is the reporting relationship to the governing body clear?
- Are expectations clear regarding what is to be managed and what outcomes are expected?
- Does the system management structure have the *capacity* to manage?
- Does the system management structure have the *credibility* to manage?

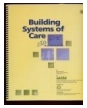
Pires, S. (2002). *Building systems of care: A primer.* Washington, D.C.: Human Service Collaborative

Governance and System Management to Address Cultural and Linguistic Competence (CLC)

- Identify/recruit members for the governing body that are reflective of the population(s) of focus.
- Create/revise policies to affirm support of CLC perspective.
- Conduct annual demographic analysis and needs assessment.
- Develop formal partnerships with cultural community agencies (e.g., faith-based entities, traditional cultural providers).
- Develop strategies to support and retain diverse board members and establish a plan for retention of a diverse workforce (e.g., training, mentoring, partnerships).
- Allocate adequate funds.
- Develop policy for timely provision of interpretation services and allocation of bilingual staff.
- Organize CLC committee with authority to assess capacity of service delivery system to be culturally competent.
- Assess (and modify if necessary) physical facilities to reflect the population of focus.
- Locate services geographically accessible and acceptable.
- Recruit, hire, train youth and their families reflecting the diversity throughout the system of care.
- Review/modify job descriptions to include requirements for development of cultural knowledge and cross-cultural practice skills.

Adapted from Sample Cultural and Linguistic Competency Plan (2008) Technical Assistance Partnership: www.tapartnership.org/cc

Families & Youth in System of Care Planning



- Work on the recruitment of families being served or reflective of the population –work with family organizations and front-line staff
- Provide assistance with transportation, child care, lodging food and…
- Invite families and youth to…
- Implement…
- Support…

Conlan, L. 2018. Parent Support Network of Rhode Island

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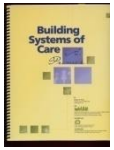
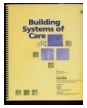
Family and Youth Partnership in Governance and System Management



- Input/evaluation of key management
- Input/evaluation of quality of services and programs
- Local system of care input
- Input into resource allocation decisions
- Service planning and implementation
- Policies and procedures
- Grievance and resolution procedures

Conlan, L. (2003). *Implementing family involvement.* Burlington, VT: Vermont Federation of Families for Children's Mental Health.



WORKSHEET

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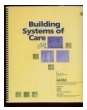

Structuring the Array of Services and Supports

stronger families

Providing the *right services* at the *right time* for families *in need.*

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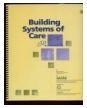
Services/Supports Array Focused on a Total Population



Universal ← → Targeted

Core Services	Prevention	Early Intervention	Intensive Services
▪ Family Support Services	→	→	→
▪ Youth Development Program/Activities	→	→	→
▪ Coordinated Intake Assessment & Service Planning		→	→
▪ Service Coordination		→	→
▪ Intensive Care Management			→
▪ Mobile Response		→	→
▪ Treatment Services		→	→
▪ School Supports		→	→
▪ School-Wide Climate Change Initiatives	→	→	→

Pires, S. & Isaacs, M. (1996, May) *Service delivery and systems reform*. [Training module for Annie E. Casey Foundation Urban Mental Health Initiative Training of Trainer Is Conference]. Washington, DC: Human Service Collaborative.

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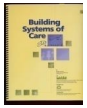
CMS/SAMHSA May 2013 Joint Information Bulletin



Intensive Care Coordination: Wraparound Approach

Parent and Youth Support Services

Intensive In-Home Services

Respite

Mobile Crisis Response and Stabilization

Flex Funds

Trauma Informed Systems and Evidence-Based Treatments Addressing Trauma

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Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions

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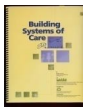


Home and Community-Based Services, Peer and Recovery Supports, Evidence-Informed Practices, Trauma-Informed Approaches

Emphasized in..

- Medicaid: CMCS/SAMHSA May 7 2013 and January 26 2015 Joint Information Bulletins
- IV-E (Child Welfare) Waivers and Family First Prevention Act
- Juvenile Justice Reform Act of 2018 (H.R. 6964)
- SUPPORT Act (H.R. 6)
- Federal Discretionary Grant Programs
- EPSDT (Medicaid) and Child Welfare Lawsuits

Service Array Considerations

Trauma-Informed Systems and Evidence-Based Trauma Treatments

- Increased awareness of the impact of trauma
- Children and youth with most challenging mental health needs often have experienced significant trauma

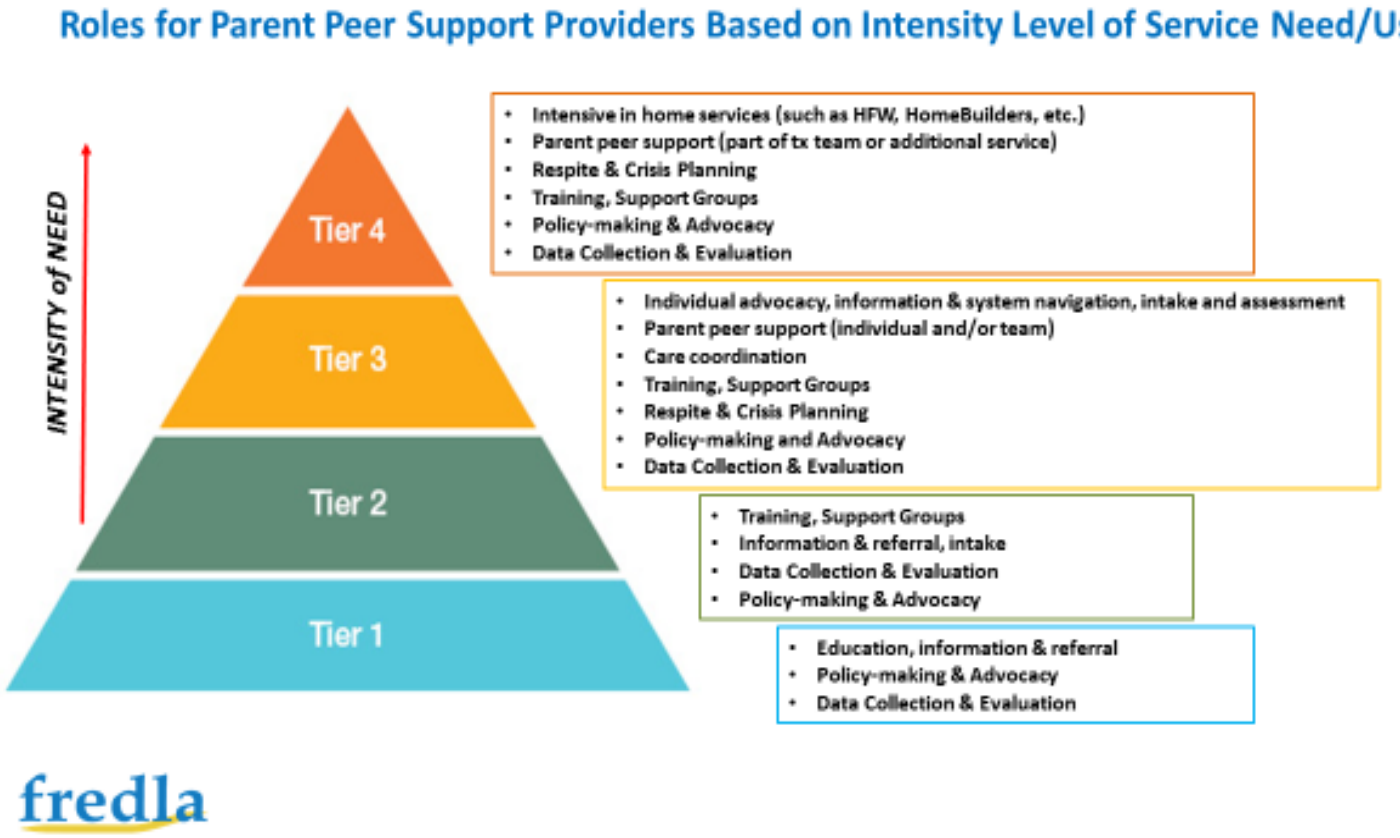
Telehealth and Mobile Technology

- Using communications technology to provide access to:
  - health/behavioral health assessment, diagnosis, intervention,
  - consultation, supervision, education, care coordination and
  - peer support across distance

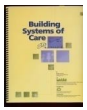
Managing and Adapting Practice

Systemic approach to raising the quality of “usual care”

Roles for Parent Peer Support Providers



Growing Conclusion by State, Tribal and Local Purchasers



Redirect spending from out of home placements with high costs and/or poor outcomes

to home and community-based services and supports in a system of care

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Pires, S. (2006). *Primer Hands On* . Washington, D.C.: Human Service Collaborative.

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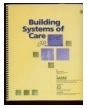
Implications for Residential Interventions



- Movement away from "placement" orientation and long lengths of stay
- Residential as part of an integrated continuum, connected to community
- Shared decision making with families/youth and other providers and agencies
- Individualized treatment approaches through a child and family team process
- Trauma-informed care

For more information, go to *Building Bridges* Initiative: www.buildingbridges4youth.org

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Data Trends #127, February 2006,University of South Florida.

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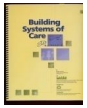
Medicaid Managed Care Organizations are Critical to System Reform



SOCs should pay attention to

- Service Array
- Quality of service implementation (MYPAC)
- Network Adequacy

What can MCOs do?

– Put families and youth with lived experience on their advisory bodies and quality review teams

– Engage families and youth with lived experience as system navigators and peer mentors

– Pay for Wraparound, peer support, respite, and mobile crisis services – if not in State Plan or Waiver, as "substitution services" to prevent higher costs

– Use reinvestment dollars to support evidence-informed approaches

– Partner with State and providers on delivering quality care and tracking outcomes

– Implement the CLAS Standards for behavioral health

– Join the System of Care initiatives in their area

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Pires, S. 2017. Human Service Collaborative

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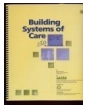
Unmet Need

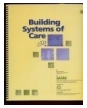


- Unmet need for care coordination is high for children and youth with mental health conditions, especially among families with public insurance or who are uninsured.

- "Parents…who receive family-center care report better…partnerships which are foundational to optimizing care coordination."

Need and Unmet Need for Care Coordination Among Children With Mental Health Conditions. Nicole M. Brown, Jeremy C. Green, Mayur M. Desai, Carol C. Weitzman, Marjorie S. Rosenthal. *Pediatrics* Mar 2014, 133 (3) e530-e537.

Unmet Need for Children with Significant Behavioral Health Challenges



Not Met by Usual Approaches

Neither traditional case management, MCO care coordination, nor health home approaches for adults are sufficient for children and youth with significant behavioral health needs

Need:

- Lower case ratios (*MO health home care coordination ratio is 1:250*; Wraparound is 1:10)*
- Higher payment rates (*MO health home per member per month rate is $78*; CHCS national scan of Wraparound care coordination rate ranges from $780 pmpm to $1300 pmpm)*
- Approach based on evidence of effectiveness, i.e. fidelity Wraparound
- Intensity of approach that is largely face-to-face, not telephonic
- Intensity of involvement with family, schools, other systems like child welfare

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L. Alexander, B. Druss, and J. Parks. "A (Health) Home Run: Operationalizing Behavioral Health Homes." Webinar, Center for Integrated Health Solutions, U.S. Substance Abuse and Mental Health Services Administration, January 2013.

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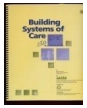
Expert Convening: Care Coordination Continuum



INTEGRATION CONTINUUM (nested within common value/principles)

Across the continuum: Family and Youth Peer Support/Navigators and Measurement-Based (Metrics Across Continuum)

All children: Pediatric primary care services, including promotion of social-emotional development, developmental and behavioral health screening, and family psychosocial screening with a broader focus on social determinants of health Could occur in primary care, behavioral health, school-based or other community setting	Children with Identified Need Child Behavioral Health Consultation Programs, which include behavioral health consultation to primary care practitioners and coordination by behavioral health Could occur in primary care, behavioral health, school-based or other community setting	Low/Moderate Need Team-based care with appropriate infrastructure (could also be in school-based health setting). Could occur in primary care, behavioral health, school-based or other community setting	Significant Need/High Risk Intensive Care Coordination using High Fidelity Wraparound (could be in primary care, behavioral health, or school-based health settings). Could occur in primary care, behavioral health, school-based or other community setting

Pires, S., Fields, S, et.al., 2018 (in process) *Care Integration Opportunities in Primary Care for Children, Youth and Young Adults with Behavioral Health Challenges: Expert Convening.* National Technical Assistance Network for Children's Behavioral Health

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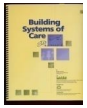
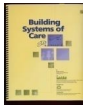
Important Points About the Wraparound Process

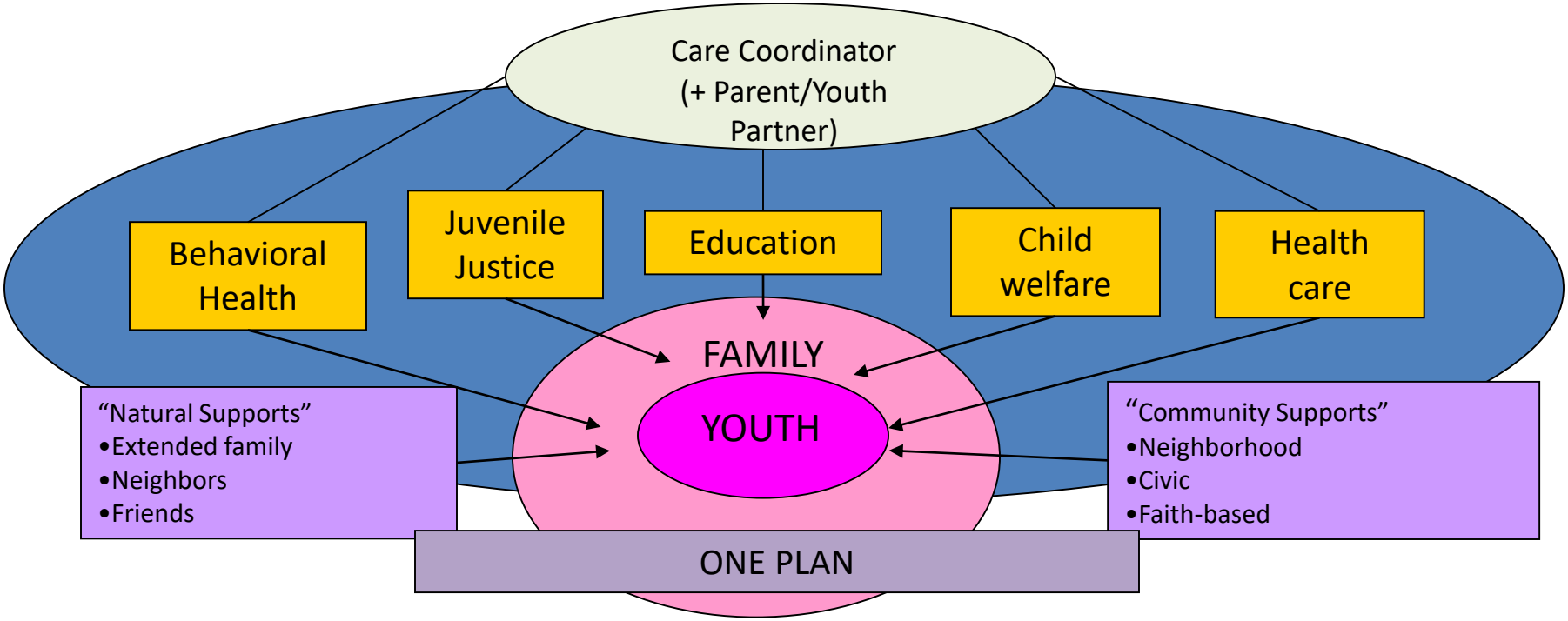


- Wraparound is a defined, team-based service planning and coordination process
- The Wraparound process ensures that there is one coordinated plan of care and one care coordinator
- Wraparound is not a service per se, it is a structured approach to service planning and care coordination
- The ultimate goal is both to improve outcomes and per capita costs of care

Bruns, E. National Wraparound Initiative

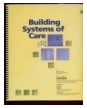
In Wraparound, a dedicated care coordinator coordinates the work of system partners and other natural helpers so there is one coordinated plan





Adapted from Laura Burger Lucas, ohana coaching, 2009

What's Different in Wraparound?



- High quality Teamwork
  - Collaborative activity
  - Brainstorming options
  - Goal setting and progress monitoring
- The plan and the team process is driven by the family and youth and "owned" by the team
- Taking a strengths based approach
- The plan focuses on the priority needs as identified by the youth and family
- A whole youth and family focus
- A focus on developing optimism and self-efficacy
- A focus on developing enduring social supports

Bruns, E. National Wraparound Initiative

Social Determinants of Health

Figure 2

Social Determinants of Health

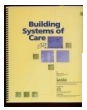
Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

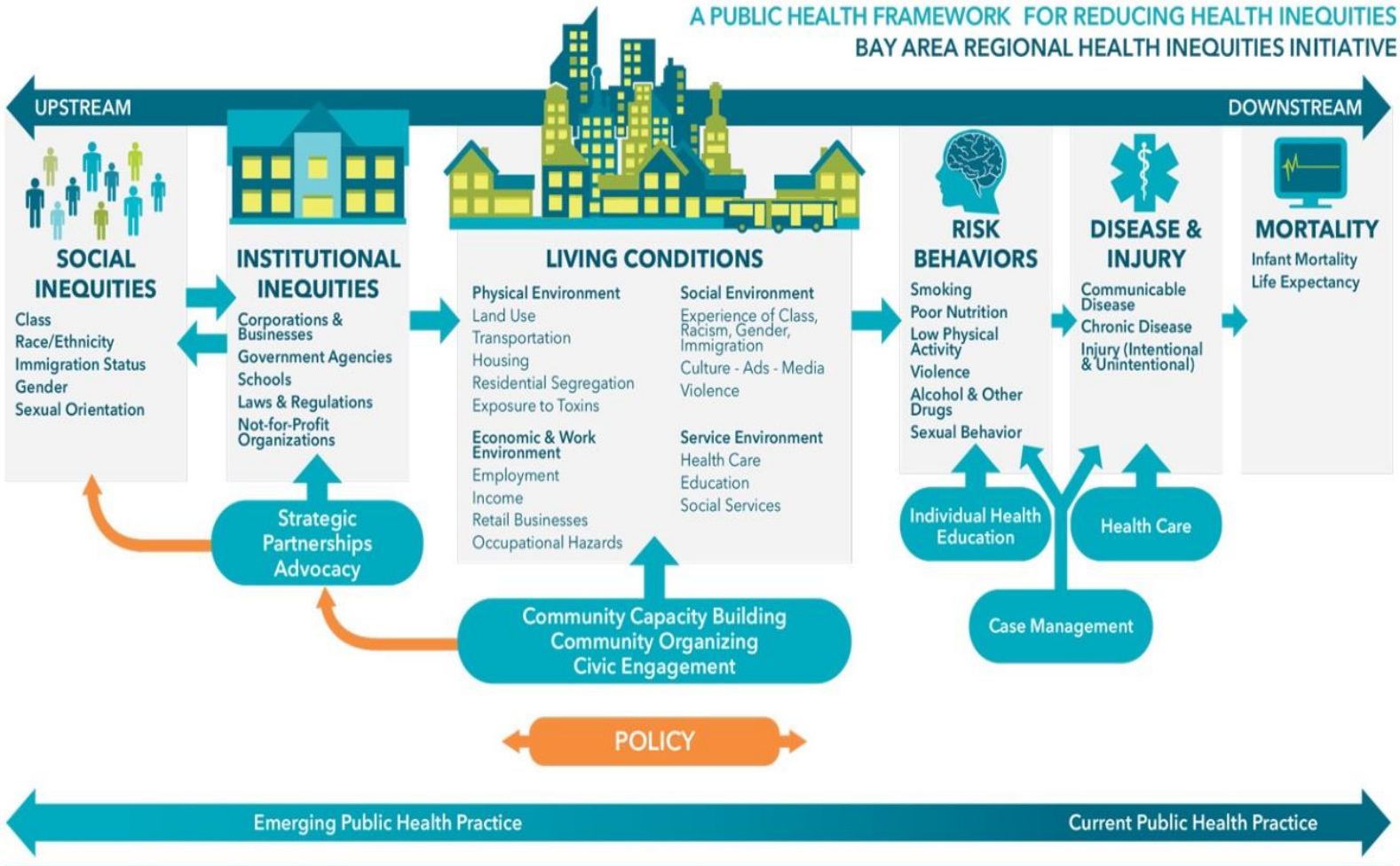
Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

THE HENRY J. KAISER FAMILY FOUNDATION

Social Determinants of Health





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Wraparound is Associated with Improved Outcomes

- Better functioning and mental health outcomes
- Reduced recidivism and better juvenile justice outcomes
- Increased rate of case closure for child welfare involved youths
- Reduction in costs associated with residential placements

See Bruns & Suter, 2010; Coldiron, Bruns, & Quick, 2017

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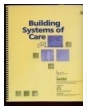
Lower Costs and Fewer Residential Stays



Wraparound Milwaukee

- Reduced psychiatric hospitalization from 5000 to less than 200 days annually
- Reduced average daily residential treatment facility population from 375 to 50 (Kamradt & Jefferson, 2008)

Controlled study of Mental Health Services Program for Youth in Massachusetts (Grimes, 2011)

- Reduced psychiatric hospitalization from 5000 to less than 200 days annually
- Reduced average daily residential treatment facility population from 375 to 50 (Kamradt & Jefferson, 2008)

CMS Psychiatric Residential Treatment Facility Waiver Demonstration (Urdapilleta et al., 2011)

- Reduced average daily residential treatment facility population from 375 to 50 (Kamradt & Jefferson, 2008)

New Jersey

- Saved over $30 million in inpatient psychiatric expenditures over 3 years (Hancock, 2012)

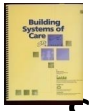
Maine

- Reduced net Medicaid spending by 30%, even as use of home and community services increased
- 43% reduction in inpatient and 29% in residential treatment expenses (Yoe, Bruns, & Ryan, 2011)

Los Angeles County Dept. of Social Services

- Found 12 month placement costs were $10,800 for wraparound-discharged youths compared to $27,400 for matched group of residential treatment center youths

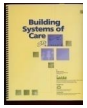
However, Outcomes Depend on Implementation



Studies indicate that Wraparound teams often fail to:

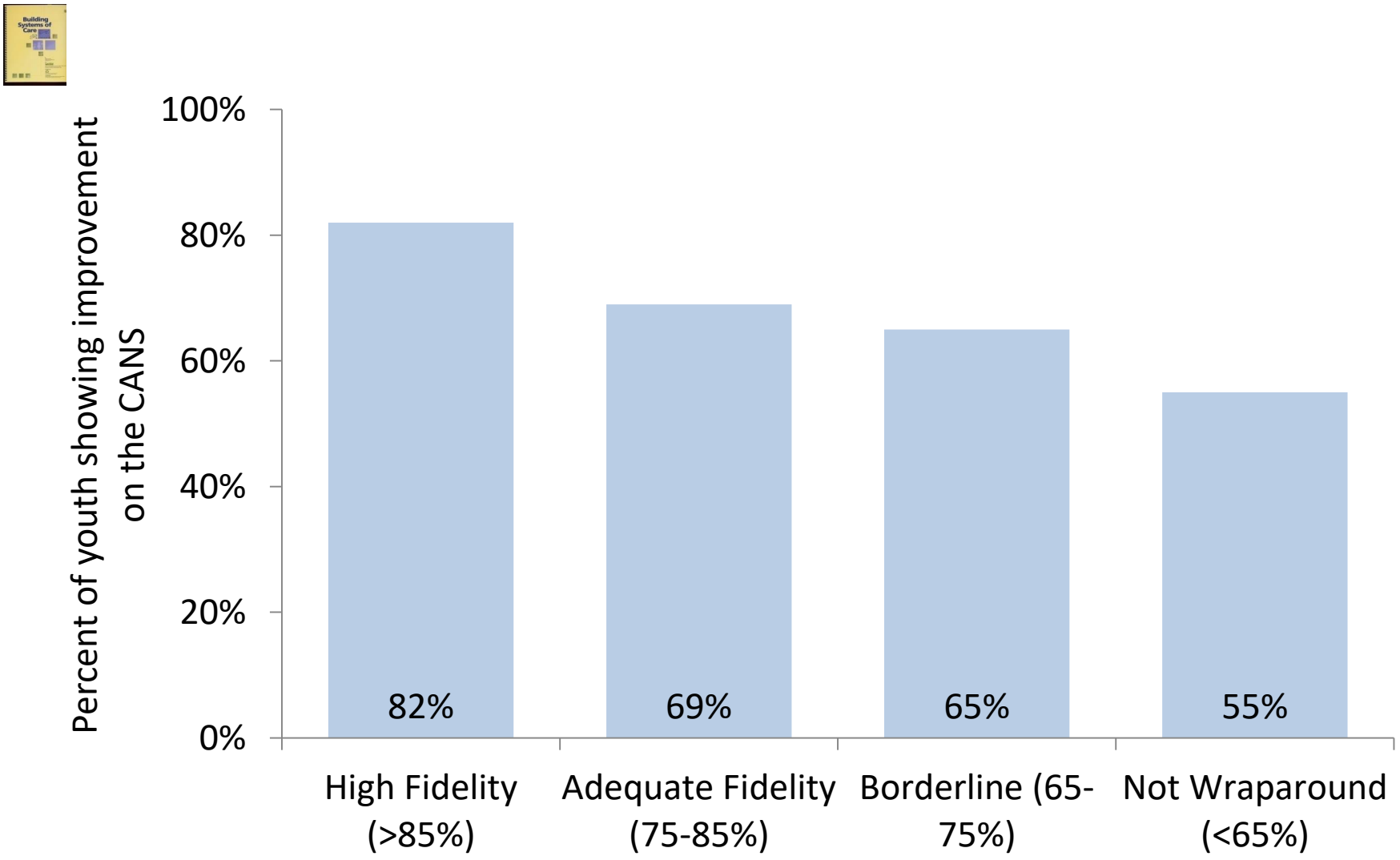
- Engage key individuals in the Wraparound team
- Connect youth in community activities and things they do well; activities to help develop friendships
- Use family/community strengths
- Incorporate natural supports, such as extended family members and community members
- Use evidence-based clinical strategies to meet needs
- Continuously assess progress, satisfaction, and outcomes

“Full Fidelity” is Critical



- Research shows
  - Provider staff whose families experience better outcomes score higher on fidelity tools (Bruns, Rast et al., 2006)
  - Wraparound initiatives with positive fidelity assessments demonstrate more positive outcomes (Bruns, Leverentz-Brady, & Suter, 2008)
- Much of wraparound implementation is in name only
  - Don’t invest in workforce development such as training and coaching to accreditation
  - Don’t follow the research-based practice model
  - Don’t monitor fidelity and outcomes and use the data for CQI
  - Don’t have the necessary support conditions to succeed (e.g., fiscal supports, comprehensive service array)

Outcomes Depend on Implementation



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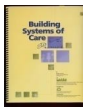
Family & Youth Partners



- Build relationship based on mutuality and trust
- Promote self-advocacy: voice & choice
- Identify and build natural supports
- Bridge of communication with providers
- Service navigation and securing community resources
- Connect to support groups and education-skills based trainings
- Assist with completing care plan goals and action steps
- Celebrate accomplishments

Conlan, L. 2018. Parent Support Network of Rhode Island

Mobile Response and Stabilization Services

- Can effectively *deescalate, stabilize,* and *improve treatment outcomes*.
- Are specifically designed to *intercede before urgent behavioral situations become unmanageable emergencies* and *are instrumental in averting unnecessary emergency department visits, out-of-home placements and placement disruptions, and in reducing overall system costs*.

Technical Assistance Collaborative.(2005). A Community-Based Comprehensive Psychiatric Response Service: An Informational and instructional monograph. Retrieved from http://tacinc.org/media/13106/Crisis%20Manual.pdf

The Historical Response to Crisis

- Emergency Departments (ED):
  - Lack specialized expertise to respond to pediatric psychiatric emergencies leads to "boarding"
  - Expensive for payers
  - Time consuming and traumatic for parents and children

Better outcomes in both cost and quality of care are achievable through community-based initiatives that redefine the meaning of ‘crisis’ and address and stabilize behaviors prior to escalation to the level of requiring inpatient care.

Goals of Comprehensive Crisis Continuum

1. Diverting unnecessary ED admissions
2. Instituting evidence-based home- and community-based services that provide meaningful alternatives to inpatient treatment

Manley, E., Schober, M. Simon, D., Zabel, M. (2018). Making the Case for a Comprehensive Children's Crisis Continuum of Care. The National Association of State Mental Health Program Directors.

Shannahan, R., & Fields, S. (2015). Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization Services. The National Technical Assistance Network for Children's Behavioral Health

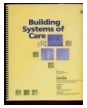
The Value of MRSS within a Crisis Continuum

- Designed to intercede upstream, before urgent behavioral situations become unmanageable emergencies
- Instrumental in averting unnecessary ED visits, out-of-home placements and placement disruptions, and in reducing overall system costs.*
- Keep a child, youth or young adult safe at home, in the community, and in school whenever possible.
- Viable alternative to acute care and residential treatment because they consistently demonstrate cost savings while simultaneously improving outcomes and achieving higher family satisfaction.

*Technical Assistance Collaborative. (2005). A Community-Based Comprehensive Psychiatric Response Service: An Informational and instructional monograph. Retrieved from http://tacinc.org/media/13106/Crisis%20Manual.pdf

MRSS Common Elements:

- Crisis is defined by the caller
- Services are available 24 hours a day, seven days a week
- Able to serve children and families in their natural environments, for example, at home or in school
- Include specialized child and adolescent trained staff and do not rely on predominantly adult-oriented crisis response workers
- Build on natural support structures and reduce reliance (and therefore costs) on hospitals and formal crisis response systems.
- Connect families to follow-up services and supports, including transition to needed treatment services



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End of Day 1

Financing

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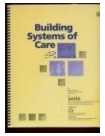
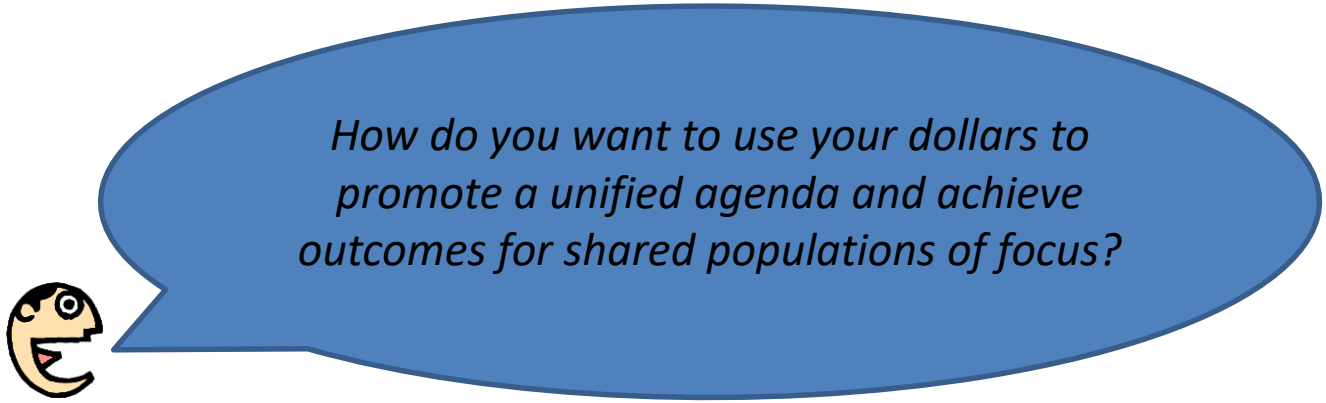
Strategic Financing Agenda



Move from a mentality of "funding programs and providing grants" to "collaborative financing to support a strategic agenda"



Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health

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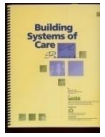

Strategic financing begins with cross-system and community stakeholders answering two questions:

Financing for <u>whom</u>???

Financing for <u>what</u>???

First Questions for Strategic Financing

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Financing for Whom?

- Identify and understand *population(s) of focus*
  - Demographics ,e.g., culture/race/ethnicity, economics, etc.
  - Size
  - Strengths, issues and needs

- Analyze Data
  - **Quantitative** – numbers or things that can be measured or counted.
  - **Qualitative** – things you can observe but are not typically in number form – social interactions, feelings, etc.

The more you understand about your population(s) of focus, the more strategic you can be about financing.

Financing for What?

What are the *outcomes* you want to achieve with respect to your identified population(s) of focus?

This is governed by your *values* – is there consensus?

Financing for What?

Does your SOC include/need the SAMHSA/CMMS recommended Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions?

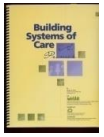
- Intensive Care Coordination/Wraparound
- Mobile Response and Stabilization Services
- Youth and Family Peer Support
- Intensive In-Home Services
- Respite Service
- Flex Funds (Customized Goods and Services)

Financing for What?

What *outreach and engagement strategies, services and supports, and care coordination approaches* will lead to effective outcomes for your identified population(s) of focus?

Is there a common "*practice approach*" you want to promote? (SOC approach – strengths-based, family-driven, youth-guided, culturally and linguistically competent, individualized, effective, comprehensive)

Financing for What?



How will services/supports be organized? What is the *system design?*

- Customization within Medicaid delivery system?
- Changes in what child welfare, juvenile justice, schools, behavioral health systems provide?
- Specialized cross-system capacity? (e.g., Care Management Entities; Family-Run Organizations; Youth-Run Organizations; screening and assessment)

What is the *administrative/system infrastructure* needed to support the delivery system?

- Training and capacity development?
- IT systems?
- Cross-agency governance?
- Social marketing/strategic communications capacity?
- Quality oversight and outcomes tracking?

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How Much Will the System of Care Cost?

- How many children/youth can you expect to use services and supports?
- How much of what are they likely to use and for how long?
- What are the costs of the services/supports in your array and of your care coordination approaches?
- What are infrastructure costs to support the system (e.g., training, IT, governance, support for family-run organizations and youth movement)?

If You Have Answered the Questions:
Financing for Whom? Financing for What?

✓Identified your population(s) of focus
✓Agreed on underlying values and intended outcomes
✓Identified services/supports and practice model to achieve outcomes
✓Identified how services/supports will be organized – system design
✓Identified the administrative/system infrastructure needed to support the delivery system
✓Estimated costs

Then You Are Ready To Talk About Financing Strategies!

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Who Controls Dollars for Your Populations of Focus?

Medicaid
- Medicaid Inpatient
- Medicaid Outpatient
- Medicaid Rehabilitation Services Option
- Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- Targeted Case Management
- Medicaid Waivers
- TEFRA Options

Child Welfare
- CW General Revenue
- CW Medicaid Match
- IV-E (Foster Care and Adoption Assistance)
- IV-B (Child Welfare Services)
- Family Preservation/Family Support
- CBCAP

Other
- TANF
- Developmental Disabilities
- Homeless Programs
- Domestic Violence
- Vocational Rehabilitation
- Housing
- Employment Services

Education
- ED General Revenue
- ED Medicaid Match
- Student Services
- Federal Grants
- Title I

Health
- Maternal and Child Health
- Public Health
- Rural and community health
- HIV/AIDS Prevention

Early Childhood
- Head Start
- Child Care
- Even Start
- Part C

Mental Health
- MH General Revenue
- MH Medicaid Match
- MH Block Grant
- MH Prevention

Substance Abuse
- SA General Revenue
- SA Medicaid Match
- SA Block Grant
- SA Prevention

Juvenile Justice
- JJ General Revenue
- JJ Medicaid Match
- JJ Federal Grants

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Cross-Agency Analysis of Expenditures and Utilization

Expenditure and Utilization Questions:

1. Which state and/or county agencies spend dollars on your population(s) of focus?
2. How much do they spend? In total and by service type?
3. What types of dollars are spent (e.g., entitlement, general revenue, block grant)?
4. How many children and youth use services? In total and by service type?
5. How much service do they use? What is average length of stay/tenure by service type?
6. What are the characteristics of these children and youth (e.g., by age, gender, race/ethnicity, diagnosis, region)?

Cross Agency Analysis of Expenditures and Utilization

Expenditure and Utilization Questions:

- Have you identified administrative challenges or barriers that need to be addressed?
- How do current financing structures support or impede SOC development?

Using Financial Analysis Data

Example: What Drives Costs (and often poor outcomes) for Youth with Behavioral Health Challenges?

- Use of Residential Treatment, Group Homes, Psychiatric Inpatient (and Day Treatment)
- Inappropriate use of psychotropic medication
- Use of traditional outpatient therapies – lack of evidence of benefit
- Duplication of Services, e.g., multiple assessments and care coordinators

Potential Opportunities

1. Braiding or coordinating funds across systems for financing services, Medicaid match, etc.
2. Using Medicaid financing to increase coverage of home- and community-based (HCB) services, shift funds from inpatient and residential care to HCB care by using guidance (e.g., joint SAMHSA-CMS Informational Bulletin, waivers such as 1915(c), etc.)
3. Leveraging innovative opportunities to finance HCB services (e.g., health homes, Money Follows the Person, 1915(i) State Plan Amendments, Medicaid and CHIP expansion)
4. Increasing the use of Mental Health Block Grant funds to fill gaps in services not covered by Medicaid or other sources
5. Opportunities across systems (e.g., Substance Abuse Block Grants, child welfare, juvenile justice, education, early childhood, etc.)

Collaborative Financing

- *Blending/pooling* – combining funds from multiple sources into one funding pool
- *Braiding* – "virtually combining" funds from multiple sources that remain administratively separate
- *Intentionally Coordinating* – agreeing across agencies to use separate funding streams for the same goals

Financing Strategies to Support Improved Outcomes for Children, Youth and Families

FIRST PRINCIPLE: Strategic Agenda for Populations of Focus Drives Financing

REDEPLOYMENT Using the money we already have The cost of doing nothing Shifting funds from high cost/poor outcome services to effective practices Moving across fiscal years	**REFINANCING** Generating new money by increasing federal claims The commitment to reinvest funds for families and children Foster Care and Adoption Assistance (Title IV-E) Medicaid (Title XIX)
RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN Donations Special taxes and taxing districts for children Fees and third party collections including child support Trust funds	**FINANCING STRUCTURES THAT SUPPORT GOALS** Seamless services: Financial claiming invisible to families Funding pools: Breaking the lock of agency ownership of funds Flexible Dollars: Removing the barriers to meeting the unique needs of families Incentives: Rewarding good practice

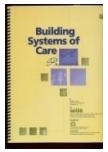
Adapted from Friedman, M. (1995). *Financing strategies to support improved outcomes for children*. Washington, DC: Center for the Study of Social Policy.

Redirection

Where are you spending resources on high costs and/or poor outcomes?

- Residential Treatment?
- Group Homes?
- Detention?
- Hospital admissions/re-admissions?
- Too long stays in therapeutic foster care?
- Inappropriate psychotropic drug use?
- “Cookie-cutter” psychiatric and psychological evaluations?

Flex Funds: Customized Goods and Services



- Purchase non-recurring set-up expenses (furniture, bedding, clothing)
- One-time payment of utilities, rent or other expenses as long as the youth and family demonstrate the ability to pay future expenses
- Academic coaching, memberships to local girls or boys clubs, etc.
- Particularly useful when a youth is transitioning from residential treatment setting to family or independent living
- Available to individuals participating in various Medicaid waivers and/or the 1915(i) program

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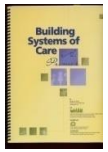
Financing Family- and Youth-Run Organizations



- State or county contracts with government agencies such as mental health, juvenile justice, child welfare, etc.
- Subcontracts with larger organization initiatives (e.g. TA Network and FREDLA)
- Medicaid reimbursement for covered services (peer support)
- Medicaid managed care organizations – reinvestment funds, "in lieu of" funds, admin dollars
- Accountable Care Organizations – system navigation, outreach, peer support, care coordination
- Private foundations
- Public awareness fundraising activities: annual campaigns, events, and donors/sponsor relationships
- Federal grants (e.g., SAMHSA Initiatives, Statewide Family Network grants, Child welfare etc.)

Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health

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What are the Opportunities for…

- Redirection of dollars to more effective approaches
- Revenue maximization
- Blending, braiding funds
- Showing a return on investment

Summary of Financing Strategies

- Maximize Medicaid
- Blend, braid or intentionally coordinate funding streams across systems
- Redirect spending from high cost and/or poor outcome services to effective practices
- Manage dollars through managed care arrangements that are tied to values and goals
- Risk adjust payment for complex populations of children (e.g., risk-adjusted capitation rates to MCOs; case rates to providers)
- Finance:
  - Locus of accountability, e.g., care management entities for most complex, cross-system
  - Family and youth partnerships at policy, management and service levels
  - Training, capacity building, quality and outcomes monitoring
  - Broad, flexible array of services and supports

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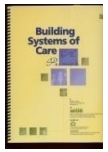

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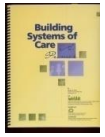
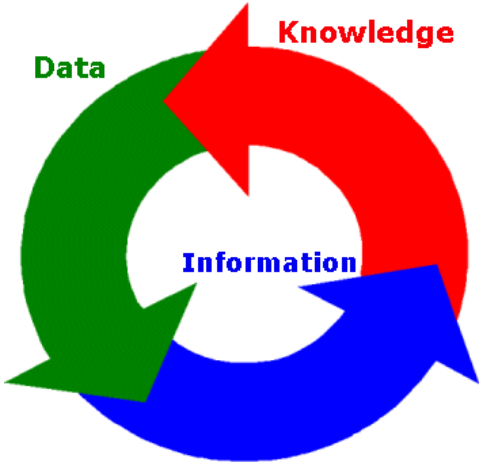


Data

"If we have data, let's look at data. If all we have are opinions, let's go with mine."

Jim Barksdale, former CEO, Netscape



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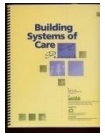
The Importance of Data



Understanding the data

=

Understanding opportunities to improve the quality and cost of care

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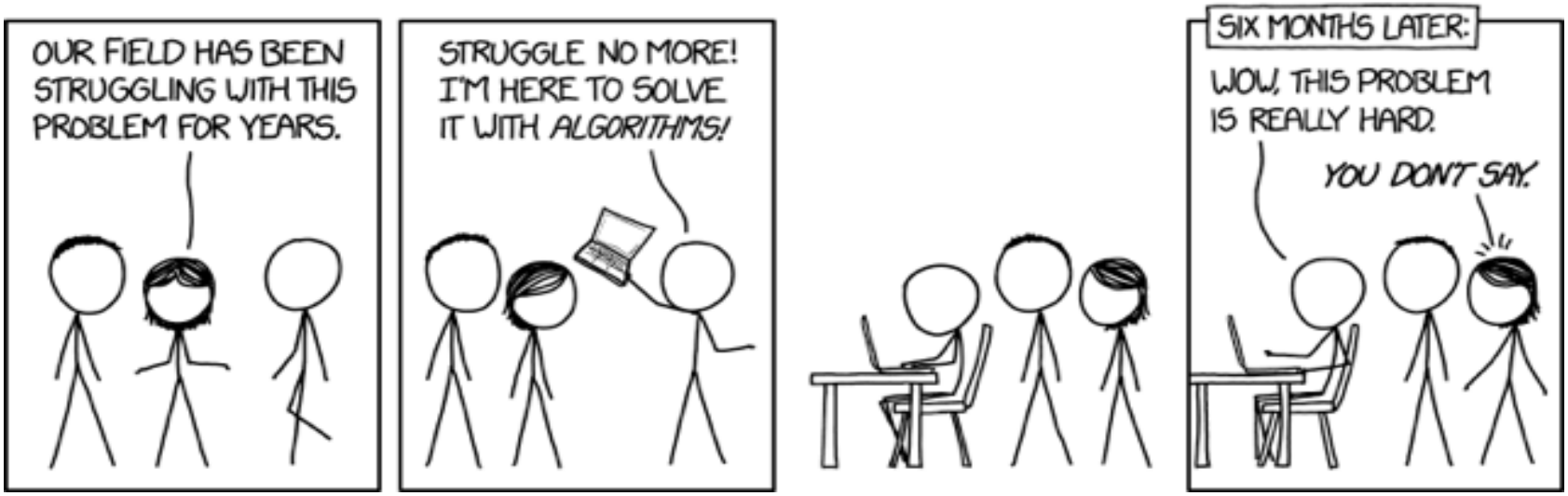
Using Data



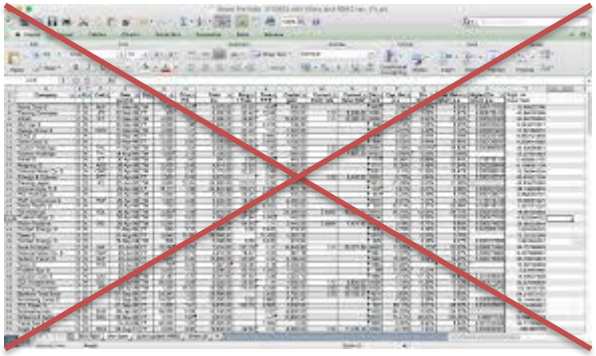
Source: https://xkcd.com/1831/

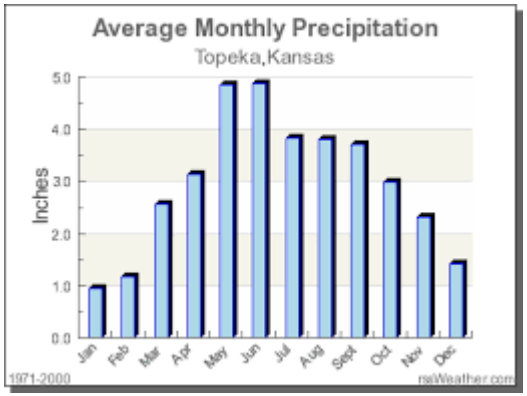
Different Uses of Data in SOCs

- Planning
- Guiding implementation
- Assessing impact – outcomes and cost
- Accountability
- Promoting and sustaining- demonstrating value
- Informing policy- and decision-makers

Presenting Data

- Simple graphs, not lists of numbers
- Clearly observable so the untrained eye can easily see the point of the data





- Data to show the importance and impact of family voice and choice

Planning- Identify, Prioritize, Size and Finance

Quantitative Data

Administrative and claims data can tell you:

- How many children use which services
- How long children stay in each type of service
- Demographics of children served in each service type (gender, race/ethnicity, geographic area)
- Health disparities (e.g. underrepresentation of Hispanic/Latino children in home and community based services) and disproportionalities (e.g. overrepresentation of African American youth in residential treatment)
- How much is being spent on each type of service, in total and on average per child served

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Sources of Quantitative Data

- Medicaid Management Information System (MMIS)
- Statewide Automated Child Welfare Information System (SACWIS)
- State and/or local behavioral health authority data
- State and/or local juvenile justice agency data
- State (e.g. special education) and/or local education data
- Data warehouses that link data elements across systems
- Provider-level data

Using Data to Identify Eligibility for Services

- Standardized screening and assessment tools
  MD-CASII
  SC- CAFAS
  GA, LA, NJ- CANS
- Standardized medical necessity criteria -MA
- State- or county-developed screening/ eligibility tools-NE, Cuyahoga County, OH

Guiding Implementation

- Referrals and enrollment by geographic area and by agency tracked over time
- Wraparound provider certification and quality review
- Use of peer support services
- Network development of key services- number and distribution of providers
- Number and length of stay in inpatient settings
- Use of home and community based services

Guiding Implementation

Qualitative Data Can Tell You

- How families and youth experience the system
- Strengths and weaknesses in the provider network
- How providers experience the system
- How key system partners experience the system (e.g. child welfare workers, juvenile probation officers, school personnel, court personnel)
- Recommendations for improvement

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Types of Measures

- **Structure** - assesses features of delivery organizations, the capabilities of their professionals and staff, and the policy environment in which health care is delivered

- **Process -** assesses the activities carried out by health care professionals to deliver services

- **Outcome** - includes health states, mortality, laboratory test results, patient reported health states

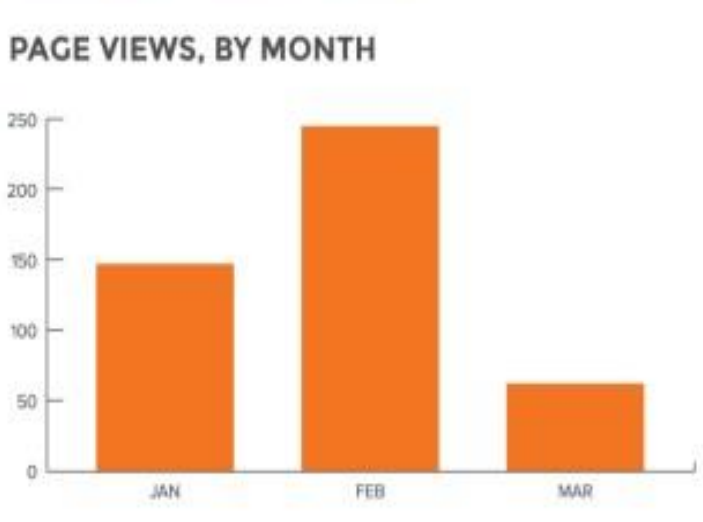
Source: Agency for Healthcare Research and Quality (AHRQ). National Quality Measures Clearinghouse. Selecting Structure Measures for Clinical Quality Measurement. Updated May 29, 2014. Available at http://www.qualitymeasures.ahrq.gov/tutorial/StructureMeasure.aspx.

Data Collection

A variable is something that can be measured or counted. It is something that can increase or decrease depending on the situation that you are measuring.

Cross-sectional Data is something that is only measured once. It is a snapshot of variables at one point in time.

Longitudinal Data is something that is measured repeatedly over time. You can look at the same variable at different times.



Pennsylvania System of Care. Data 101 – The Basics. https://www.pacarepartnership.org/uploads/Tip_Sheet_1_-_Data_101_Basics.pdf

Accountability Functions

- Utilization Management
- Quality Improvement
- Cost and Outcome Monitoring

Pires, S.A. Primer Hands On – Human Service Collaborative, Washington, D.C.

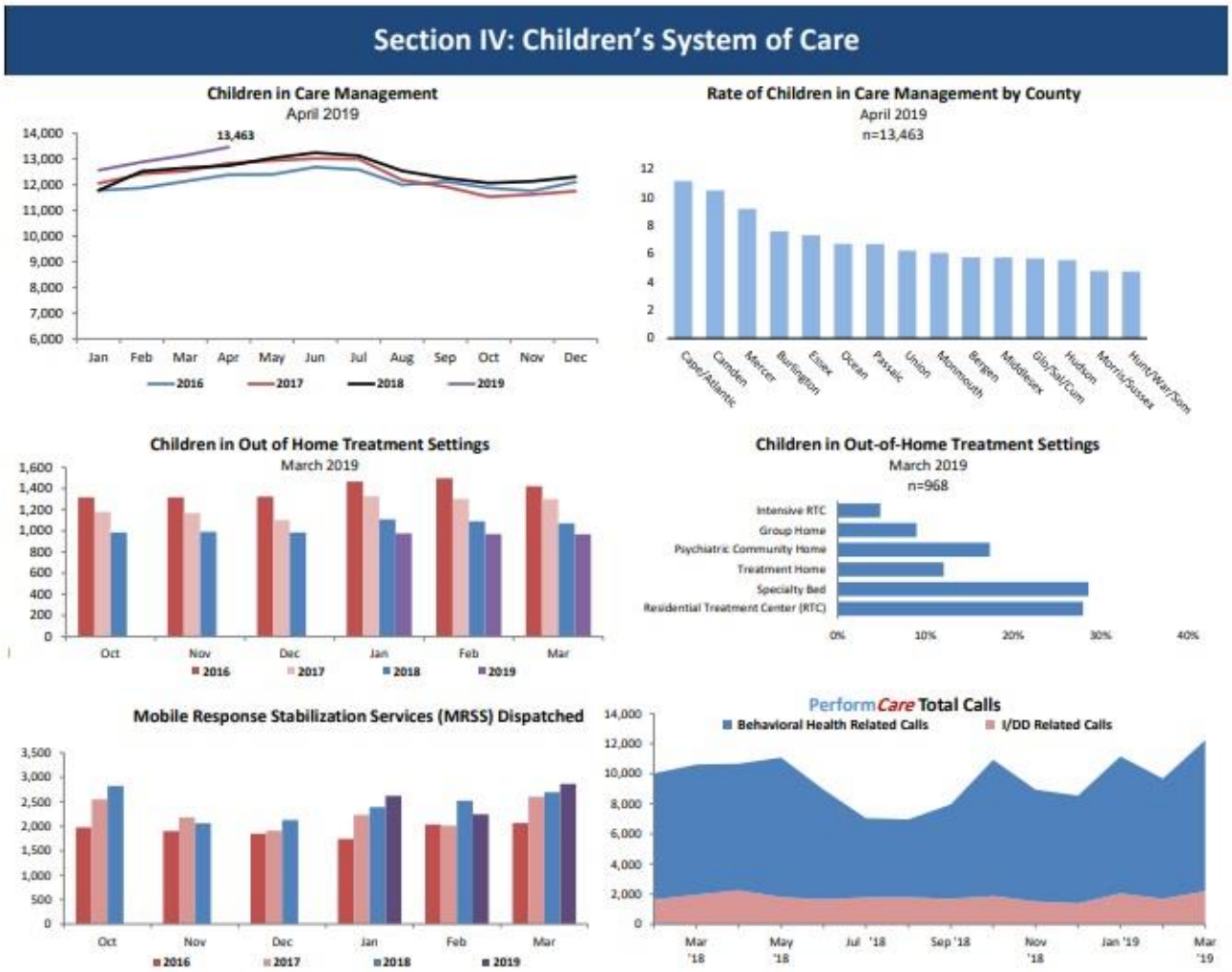
Performance Dashboards

- Benefits: fosters alignment, continuous quality improvement (CQI), transparency

- Considerations
  - Purpose: audience & use; strategy or operations?
  - Metrics: <10, actionable, simple, agreed upon, linked to goals, use credible data
  - Timing: past snapshot, now, predictive
  - Visualization: trends, “meters”, pie/bar charts, hot spots/heatmaps. Show relationships? Interactive or static?

- Can’t be everything to everyone. Dashboards provoke questions and further investigation

New Jersey Dashboard



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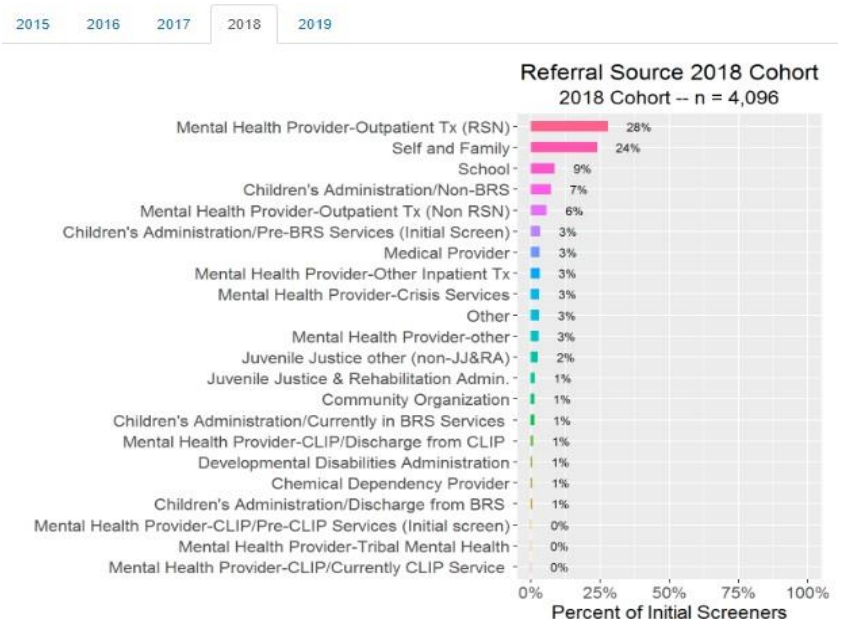
Washington and Vermont Dashboards



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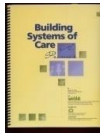
Demonstrating Value

Build support for sustainability and expansion

- Educate leadership and funders
- To build internal staff support
- Build stakeholder support
- Support of agency leadership
- Show return on investment

Gathering Data

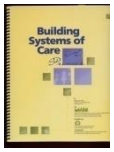


- Questionnaires
- Surveys
- Interviews
- Focus groups
- Clinical outcome data
- Claims/administrative data

- Participatory action research
- Network analyses
- Financial analyses
- Chart reviews

Lazear, K. (2003). *"Primer Hands On" A skill building curriculum.* Washington. D.C

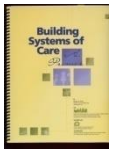
Continuous Quality Improvement (CQI)



Plan, Do, Study, Act (PDSA) Cycle

- ✓Accountability
- ✓Driven by good management...not crisis
- ✓Driven by input from all levels of staff and stakeholders including families and youth
- ✓Teamwork
- ✓Continuous review of progress

Why Analyze Medicaid Data



- Medicaid is the largest funder of behavioral health care for children and youth
- To be effective and sustainable, system of care reforms must impact Medicaid delivery systems
- Understanding child behavioral health utilization and expense in Medicaid can guide quality improvement efforts affecting most children and youth involved with systems of care

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Pires, S. 2016. Human Service Collaborative: Washington DC

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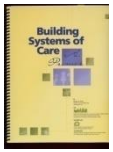
Why Analyze Medicaid Data



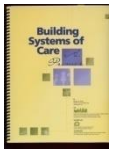
- *Can Identify Opportunities to:*

Maximize Medicaid and re-direct spending from high-cost, poor outcome spending – e.g. from facility-based care to home and community-based services, peer support and effective care coordination using fidelity Wraparound

Address appropriate use of psychotropic medications

Address disparities and disproportionality in access, in type of service used, in psychotropic medication rate and use - based on gender, age, race and ethnicity, aid category (TANF, Foster Care, SSI/Disabled) and geography

Why Analyze Medicaid Data



- Can project number of children with co-morbidities by examining physical health use and expense among children who use behavioral health care
- Can identify children with top 10% most expensive use to project numbers for health homes and intensive care coordination using Wraparound
- Can compare your State's utilization and expenditures to national child behavioral health use and expense
- Can establish benchmarks related to system of care goals (e.g., access, reduced disparities, increased use of home and community based services and peer support, reduced use of facility-based care)

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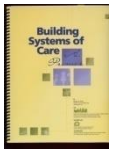
Faces of Medicaid: Examples of Promising Findings



- Penetration rates ↑ overall
- Greater access by most racial/ethnic groups
- Greater access by girls
- Greater access by 0-5 population
- Use of broader range of home and community-based services

Pires, SA, Gilmer, T, Allen, K., McClean, J. 2017. *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures Over Time, 2005-2011*. (In process). Center for Health Care Strategies: Hamilton, NJ

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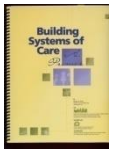
Faces of Medicaid: Examples of Concerning Findings



- 8% penetration rate for use of BH *services* (while up), remains well below prevalence estimates of need
- Disproportionately low rates of use for Hispanic/Latino, Asian, and Native Hawaiian/Pacific Islander children
- Disproportionately low utilization rates for girls
- Disproportionately low rates of use for 0-5 population
- Residential treatment ↑
- Inpatient psychiatric ↑
- Persistently high rates of residential treatment and inpatient psych use for foster care population
- Rate of psychotropic medication use ↑, and close to half of children on meds did not receive accompanying behavioral health services
- Utilization rates of peer support, MST, Wraparound (while up) remain very low

Pires, SA, Gilmer, T, Allen, K., McClean, J. 2017. *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures Over Time, 2005-2011*. (In process). Center for Health Care Strategies: Hamilton, NJ

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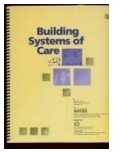
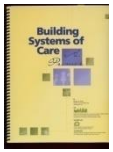
Faces of Medicaid: Types of Questions/Issues Raised by Data

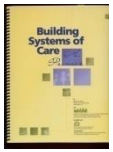


- Most frequent diagnosis for 0-5 population was Conduct Disorder – May mask learning problems? Trauma?
- Rate of PTSD diagnosis at 6% may be low?
- ADHD remains most frequent diagnosis – are children being over-diagnosed?
- Black/African American children most likely to receive ADHD diagnosis and least likely to receive diagnoses of Mood Disorder, Anxiety and PTSD – are these children being misdiagnosed?
- Children in Medicaid using BH care are 11% of the Medicaid child population and consume 36% of all Medicaid child expenditures, and their mean expense is over 4x that of children who do not use BH care – what are the best value-based strategies for improving the cost and quality of care for these children?

Pires, SA, Gilmer, T, Allen, K., McClean, J. 2017. *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures Over Time, 2005-2011*. (In process). Center for Health Care Strategies: Hamilton, NJ



WORKSHEET



Final Thoughts?

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SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Pat Hunt
Family-Run Executive Director Leadership Association (FREDLA)
phunt@fredla.org

Shannon Robshaw & Melissa Schober
The TA Network for Children's Behavioral Health
Srobshaw@ssw.umaryland.edu Melissa.Schober@ssw.umaryland.edu

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)